Clinical Documentation Improvement Toolkit

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Foreword

Clinical documentation is the foundation of every health record, and high-quality clinical documentation is the goal of every clinical documentation improvement (CDI) program. In spite of this goal, consistent, high-quality documentation can be difficult to achieve without a structured CDI program.

This toolkit provides many of the necessary tools and documents needed for implementing and/or maintaining a robust CDI program. While the information contained in this toolkit is comprehensive, it is by no means inclusive of all the possibilities for a successful program. Users of this toolkit should refer to the AHIMA practice brief "Guidance for Clinical Documentation Improvement Programs" for additional information.

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Introduction

This toolkit will be helpful to physicians, hospital administrators, health information management professionals, nursing staff, and others in the acute care hospital setting. This introduction provides a high-level overview of the background, purpose, and mechanisms for CDI programs.

Background

Clinical documentation in the health record is critical to the patient, the physician, and the healthcare organization. Acute care hospitals, in particular, have become more dependent on physician (provider) documentation in order to comply with the Centers for Medicare and Medicaid Services (CMS) regulations regarding quality and reimbursement. Clinical documentation improvement (CDI) programs began in the 1990s to assist physicians in their documentation efforts.

In October 2007 CMS implemented Medicare Severity Diagnosis Related Groups (MS-DRGs) for hospital inpatient prospective payment in order to better reflect the patient's severity of illness and expected risk of mortality. The patient's principal diagnosis and co-morbid conditions determine these two assessments; thus, the need for complete and accurate documentation takes on a more important role.

One year later, October 2008, CMS began to require a Present on Admission (POA) indicator for all coded diagnoses in order to identify conditions that are present when a patient is admitted from those that are acquired once in the hospital.

Finally, the mechanism by which acute care hospitals receive Medicare reimbursement for patients under the Medicare Advantage or Part C payment structure also relies heavily on documentation and coding for capturing patient conditions, which drives severity and reimbursement as well.

Improved clinical documentation will also improve outcomes data and assist in preparing the healthcare entity for a variety of future payment methodologies. It plays a part in compliance with national core measures. Clinical documentation that is precise, thorough, and accurate can provide a defense for regulatory compliance reviews, including the Recovery Audit Contractor initiative, Zone Program Integrity Contractors, and Medicaid Integrity Contractors program.

With these regulatory and payment changes, acute care hospitals have started new documentation improvement programs or embellished their current documentation improvement practices and processes. Documentation is then translated into ICD-9-CM codes.

What Is CDI?

The purpose of a CDI program is to initiate concurrent and, as appropriate, retrospective reviews of inpatient health records for conflicting, incomplete, or nonspecific provider documentation.

These reviews usually occur on the patient care units or can be conducted remotely (via the EHR).

The goal of these reviews is to identify clinical indicators to ensure that the diagnoses and procedures are supported by ICD-9-CM codes. The method of clarification used by the CDI professional is often written queries in the health record. Verbal and electronic communications are also methods used to make contact with physicians and other providers. These efforts result in an improvement in documentation, coding, reimbursement, and severity of illness (SOI) and risk of mortality (ROM) classifications.

Often CDI programs begin with focused concurrent review of a specific payer type (e.g., Medicare) or payment type (e.g., DRG), but this is not a requirement and the focus will depend on the individual organization.

Although CDI programs are traditionally found in the acute inpatient setting they are being implemented in other healthcare settings such as acute rehabilitation hospitals and skilled nursing facilities.

Who Are the CDI Staff?

Individuals qualified to serve in these roles include, but are not limited to, health information management professionals, physicians, nurses, and other professionals with a clinical and/or coding background.

Depending on the makeup of the CDI program, the program may be staffed entirely by HIM coding professionals, entirely by RNs, or a combination of both. In some programs there may be dedicated physician liaisons or "champions" who conduct reviews and communicate with other physicians on documentation issues.

Skills and attributes for these individuals include, but are not limited to, clinical knowledge, payment systems and methodologies, ICD-9-CM coding concepts and guidelines, healthcare regulatory compliance, work experience in the hospital acute care setting, and strong verbal and written communication skills.

For purposes of this toolkit, the term "CDI professional" encompasses the following titles: clinical documentation specialist (CDS), clinical documentation improvement specialist (CDIP), documentation specialist, and other similar titles.

A sample job description appears below on page 8. For more information, visit the AHIMA Web site at www.ahima.org.

Key CDI stakeholders include:

- Health information management and coding departments
- Case management and utilization review
- Medical staff and physician leadership
- Executive leadership
- Patient financial services or billing

- Finance and revenue cycle
- Quality management
- Nursing staff
- Compliance

What Are CDI Goals?

- Identify and clarify missing, conflicting, or nonspecific physician documentation related to diagnoses and procedures
- Support accurate diagnostic and procedural coding, DRG assignment, severity of illness, and expected risk of mortality, leading to appropriate reimbursement
- Promote health record completion during the patient's course of care
- Improve communication between physicians and other members of the healthcare team
- Provide education
- Improve documentation to reflect quality and outcome scores
- Improve coders' clinical knowledge

The CDI educational component must be supplemented and complemented by usable, efficient, compliant, and meaningful documentation tools that enhance physicians' optimal patient care workflow. This concept must be part of the CDI equation to achieve success. Such a program will not only be effective, it will be cost-effective, because the documentation tools can also undergo continuous improvement to meet the sophisticated reporting needs being presented.

CDI programs may also provide new strategies, physician tips, and tools to move the program to success. A newsletter or articles on documentation improvement help demonstrate the benefits and increase collaboration and participation in the program.

Tracking the CDI program results is key to demonstrating that the goals of the program are being achieved. This will also provide insight into the data and patient care profiles.

CDI Testimonials

"I think the CDI program at our institution has been very useful on several levels—it raises awareness among staff physicians of some of the challenges facing a modern hospital, it reminds physicians to look more closely at some areas of care they may otherwise have regarded as less important. A surprising effect is that I think it's helped to build a kind of camaraderie among some of the physicians as they work together to help their hospital do well."

—M. Sabrina Daroski, MD, FACP, Internal Medicine
Medical Staff President, St. Clair Hospital
Physician Coach/CDI Program, Pittsburgh, PA

"We have 'home grown' our CDI program from the ground up in the last couple of years. Since implementation, HIM coding has gained much more visibility with the physicians and clinical staff. We have enhanced our working relationships with the quality management staff as we work together on quality reporting initiatives and have gained a better understanding of how our

roles interrelate. As the CDI roles have evolved, we have gained more recognition and respect for the jobs that we do and the value of the efforts that we put forth."

—Tammy R. Love, RHIA, CCS
HIM Coding Manager
UAMS Medical Center
Little Rock, AR

"I have found in my own pulmonary practice that understanding the linkage of medical terminology and ICD-9-CM inpatient documentation requirements has empowered me to legitimately and optimally impact my performance profile and Evaluation and Management (E&M) payment, as well as provide my hospital the correct reimbursement for my patient care."

—William Haik, MD, FCCP
Director, DRG Review, Inc.
Florida

Summary

Having a CDI program with dedicated and highly trained staff to review and monitor documentation adds great value to many aspects of the healthcare industry. By emphasizing the documentation requirements necessary for the capture of patient severity, acuity, and risk of mortality, healthcare providers can improve clinical data used for research, quality scorecards, and patient safety. As a result of more thorough documentation, CDI programs more accurately reflect reimbursement for the resources used and services provided.

Sample CDI Job Description

Clinical Documentation Improvement (CDI) Professional (Inpatient)

Job Summary:

Facilitates and obtains appropriate physician documentation for any clinical conditions or procedures to support the appropriate severity of illness, expected risk of mortality, and complexity of care of the patient

Exhibits a sufficient knowledge of clinical documentation requirements, DRG assignment, and clinical conditions or procedures

Educates members of the patient care team regarding documentation guidelines, including attending physicians, allied health practitioners, nursing, and case management

Responsibilities:

Completes initial reviews of patient records within 24–48 hours of admission for a specified patient population to: (a) evaluate documentation to assign the principal diagnosis, pertinent secondary diagnoses, and procedures for accurate DRG assignment, risk of mortality, and severity of illness; and (b) initiate a review worksheet

Conducts follow-up reviews of patients every 2–3 days to support and assign a working or final DRG assignment upon patient discharge, as necessary

Queries physicians regarding missing, unclear, or conflicting health record documentation by requesting and obtaining additional documentation within the health record when needed

Educates physicians and key healthcare providers regarding clinical documentation improvement and the need for accurate and complete documentation in the health record

Collaborates with case managers, nursing staff, and other ancillary staff regarding interaction with physicians on documentation and to resolve physician queries prior to patient discharge

Participates in the analysis and trending of statistical data for specified patient populations to identify opportunities for improvement

Assists with preparation and presentation of clinical documentation monitoring/trending reports for review with physicians and hospital leadership

Educates members of the patient care team regarding specific documentation needs and reporting and reimbursement issues identified through daily and retrospective documentation reviews and aggregate data analysis

Facilitates change processes required to capture needed documentation, such as forms redesign

Partners with the coding professionals to ensure accuracy of diagnostic and procedural data and completeness of supporting documentation to determine a working and final DRG, severity of illness, and/or risk of mortality

Reviews and clarifies clinical issues in the health record with the coding professionals that would support an accurate DRG assignment, severity of illness, and/or risk of mortality

Assists in the appeal process resulting from third-party reviews

Qualifications/Experience:

The CDI professionals can be, but are not limited to, HIM professionals, nurses, physicians, and other healthcare professionals with a clinical and/or coding background. The typical individual includes a health information management professional with at least 2 years inpatient coding experience and/or an RN with at least 2 years acute care nursing experience (e.g., medical-surgical, ICU, case management, etc.).

CDI Review Forms and Tools

A variety of tools are available to support the documentation improvement process. Following are several examples. Organizations may customize these tools to meet their particular needs.

CDI Clarification Form

The CDI clarification form is what traditionally has been referred to as a physician query. The terms *clarification* and *query* can be used interchangeably. In order to differentiate requests by a CDI professional from those of a hospital HIM coder, the term *clarification* is often used, but it has many of the same purposes. Some organizations may chose to refer to the CDI document as a physician query.

For purposes of this toolkit, the term *query* will be used to identify the physician communication tool. Other terms synonymous with query include clarification, clinical clarification, documentation alert, and documentation clarification.

A sample CDI clarification form follows on the next page.

Health Record Identification
Organizations are free to determine the amount of information needed to link the request for clarification to the health record. Clarifications that are kept as part of the health record will require more patient information than those that are only part of the business record or those that are shredded when the record is complete. Organizations should seek the advice of legal counsel pertaining to the retention of this information.

Explanation to the Medical Team
The clarification form includes a brief explanation of what is required from the attending medical team. The sample form provided here is not designed to be part of the health record, so organizations planning to use it in that manner will need to modify it accordingly.

In order to prove the validity of the request for documentation clarification, the form requires the CDI professional to provide the clinical indicators and/or medical evidence that prompted the request for information. Some organizations may choose to have templates specific to certain diagnoses (e.g., heart failure, with preprinted clinical indicators such as ejection fraction < 40%), whereby the CDI professional would check the indicators and their location in the health record. The location in the health record allows others to verify the presence of the supporting data as well as allowing the physician to make any corrections to the original documentation if warranted (e.g., if the entry was incorrect).

Requests for clarification should not be based solely on reimbursement factors. When posing a question, the CDI professional should avoid questions that can be answered with a simple yes or no response. Multiple choice options should include the reasonable and clinically supported diagnosis, including “other” and “undeterminable” as a standard best practice. Options should follow the AHIMA practice briefs “Managing an Effective Query Process” and “Guidance for Clinical Documentation Improvement Programs” in order to ensure a compliant approach.

Clinical Documentation Improvement Clarification Form

Date: _____ Patient Name: _____

CDI Professional: _____ Health Record Number: _____

CDI Professional Phone #: _____ Account Number: _____
(or place patient sticker)

Attention Medical Staff:

A review of the health record by the Clinical Documentation Team found a need for documentation clarification. There are clinical indicators in the health record of a **missed and/or incomplete diagnosis**. The relevant information is provided below for your expedited review.

Please address these findings in the health record by providing an applicable diagnosis and/or clarification of an existing diagnosis in the next progress note, dictated report, discharge summary, and/or in an addendum.

A response is requested within 24 hours.

Clinical Indicators/Medical Evidence	Location in the Health Record
1.	1.
2.	2.
3.	3.
4.	4.

Please address the question listed below and/or consider one of the diagnoses commonly associated with the clinical indicators that can be captured by coding.

Please note that a lack of response to this request does not reflect disagreement. If no additional documentation is warranted, please check the following box:

☐ I disagree with the need for additional documentation.

Reminder: ALL documentation MUST occur in the health record. This form is NOT part of the health record.

Thank you for your prompt response to this clarification request!

CDI Quality Assurance Audit Tool

The CDI quality assurance (QA) audit tool helps monitor the work of the CDI professional. Although there are quality and quantity standards in place for coding professionals, these programs may not have standards specific to those coders who perform CDI functions. In addition, CDI programs can be staffed by nurses or other clinicians who would be unfamiliar with the standards applied to coders.

CDI is still a relatively new program so it is important for a facility to have checks and balances in place to ensure the highest level of integrity as CDI programs are likely to be scrutinized during external audits, including those by Recovery Audit Contractors (RAC). When developing a CDI program, having a strong QA process can aid in achieving a successful and compliant program.

Currently, there are no recommendations as to how often these reviews should be completed and what volume of cases should be reviewed. The frequency and volume of QA review may be greater for a new CDI staff member or at the beginning of program implementation. It is recommended that each organization specify the frequency and volume of audits within its departmental policy.

A sample CDI QA audit tool follows on page 14. It can be customized as applicable to specific CDI programs. Some healthcare organizations may wish to add customized questions or may delete questions that are not applicable.

Identification of the Health Record
This section collects information to identify which health record is being audited. The review date corresponds to the date of the audit as the date of the CDI review is captured in a later field.

Review Questions
These questions are designed to capture the work of the CDI professional. Not all questions will apply to every review.

If a physician query is issued, there are questions related to the rationale for issuing the query as established by the AHIMA query practice brief to ensure the appropriateness. In addition, to support the appropriateness of the query, there must be evidence of a missing or incomplete diagnosis to illustrate the query is not an attempt to introduce new information into the health record. The CDI QA process should address these areas.

The question of leading queries should be customized to reflect the organization's policy on leading queries. The AHIMA practice brief "Guidance for Clinical Documentation Improvement Programs" provides additional information and examples related to leading/nonleading queries.

If the above elements are met and the issued query did not rely on a yes/agree or no/disagree response, the query will most likely not be perceived as leading. Because CDI programs may use query forms that are not part of the record, it is important to ensure the revised documentation is present in the health record.

The physician response is twofold: did the physician respond, and if so, what was the physician's response. Lack of response represents a different problem than a lack of agreement. A low agreement rate by the physicians may be an indicator of inappropriate queries or poorly constructed queries. Conversely, an agreement rate of 100 percent may also be indicative of a problem, as physicians may not perceive the ability to disagree with queries. Each organization needs to determine what is an appropriate response rate and agreement rate for its staff.

The next series of questions focus on the ability of the CDI professional to correctly identify the need for additional documentation and additional reviews. This section may be of particular use with those who are new to the CDI role.

The final questions seek to identify differences between the final working DRG as determined by the CDI professional and the billed DRG. Departments in which the CDI professional is not a coder may expect DRG disagreements due to coding rules, inadequately capturing procedures, and complicating conditions that arise after the CDI review; however, other causes of disagreements may be learning opportunities for the CDI professional (e.g., a CC that cannot be verified by coding, a CC found by coding that was missed by the CDI professional, etc.).

Clinical Documentation Improvement Quality Assurance Audit Tool

Name of CDI staff: _____ Review date: _____

MR# of reviewed chart: _____ Admission Date: _____ D/C Date: _____

Date of Initial CDI review: _____ Date of subsequent review(s) _____

Which of the following was the rational for issuing the query? The documentation was *(circle all that apply)*:

Illegible Incomplete Unclear Inconsistent Imprecise Conflicting documentation

	If **Yes** Enter 1	If **No** Enter 1
Did the query contain relevant medical evidence?		
Could the query be perceived as leading?		
Did the physician respond to the query?		
Did the physician agree with the recommendation?		
Was the additional documentation added to the health record?		
Were all opportunities for Present on Admission (POA) clarified?		
Was there clinical evidence of a diagnosis, which did not result in a query?		
Was there clinical evidence of a procedure, which did not result in a query?		
Were subsequent reviews performed?		
If more than one review occurred, were the subsequent reviews at appropriate intervals?		
Was the working DRG revised during the review process?		
Was the final working DRG the same as the billed DRG?		
If not, what was the difference between the two DRGs i.e., CC found, CC not verified, etc.?		
What were the medical evidence and the possible diagnosis and/or procedure?		

General comments/suggestions:

CDI Review Form

This form is used to assist a CDI professional performing a concurrent review of a health record in acquiring relevant data to complete an accurate review. Some CDI programs have electronic tools into which concurrent reviews are directly entered.

A sample form begins on page 17.

Patient Demographics
Facilities may customize this section to include additional demographic fields as necessary. Only the minimum number of fields for identification is included on this form.

The health record number is entered into the medical record number (MR#) field. This is the identification number that is consistent across all encounters for a particular patient.

The account number is the identifier unique to this specific patient encounter.

The financial class identifies if the patient has a DRG payer and which DRG version is appropriate.

The attending physician is the physician of record to whom queries will be posted as applicable.

Initial Review General Information
The name of the CDI professional performing the review is entered into the CDS field.

The current length of stay is entered into the LOS field.

The working DRG should include the applicable DRG and denote into which tier the DRG falls (i.e., single, w/MCC, w/o MCC, w/CC).

The geometric length of stay (GLOS) is associated with the particular working DRG and is compared to the actual LOS.

Some facilities may choose not to include the relative weight; however, this information is useful when comparing DRGs.

Those facilities that use the APR Grouper will have access to the Severity of Illness (SOI) and Risk of Mortality (ROM) scores, which are useful in reviewing records for their impact on the mortality index.

Relevant secondary diagnoses represent those diagnoses that impact the DRG, SOI, or ROM (i.e., the diagnosis that gives the CC and/or MCC to the DRG or a diagnosis that requires clarification in order to add a CC/MCC), or can include diagnoses that require clarification of their present on admission (POA) status.

The location in the health record is to allow independent verification by coding and other auditors of the record.

The relevance clarifies how the diagnosis impacts the DRG and/or SOI/ROM.

Query Information
In order to place a valid query there must be clinical evidence of a missing or incomplete diagnosis in the health record; therefore, this section is where the clinical evidence warranting the query is documented (e.g., EF of 35% with diagnosis of CHF)

The location in the health record is to allow independent verification.

The desired diagnosis and its significance are noted in the desired outcome/relevance field to expedite follow up by the CDI professional (e.g., chronic systolic HF adds CC).

The outcome of the query is captured in the next few fields.

For information regarding the revised DRG section, see above under working DRG bullets.

Disposition
Disposition can be completed without the completion of a query as a review may be completed on the first review; however, if additional reviews are required, the CDI professional can document when the next review should occur.

Subsequent Review
The CDI professional will review the working or revised DRG from the above section and review the chart for evidence of missing or incomplete diagnoses using the sections described above. Additional pages can be added to increase the number of subsequent reviews.

Clinical Documentation Improvement Review Form

MR #	Account #	Financial Class	Attending Physician
Initial Review			
CDS:	Date of review:	LOS:	GLOS:
Working DRG:	Relative weight:	SOI:	ROM:

Principal diagnosis:	Principal procedure:

Relevant secondary diagnoses:	Location in the health record:	Relevance (i.e., CC/MCC, ROM, POA):
Query opportunity/need for additional documentation:		
Clinical indicators/medical evidence:	Location in the health record:	Desired outcome/impact:
Physician Response: Yes___ No___	Date of response:	Physician agreed w/ request: Yes___ No___

Revised DRG:	GLOS:	Relative weight:	SOI:	ROM:

Principal diagnosis:	Principal procedure:

Disposition:	Review closed ___	Follow up review required ___	Date of next review:
General comments:			

Subsequent Review(s)		
CDS:	Date of review:	LOS:
Relevant secondary diagnoses:	Location in the health record:	Relevance (i.e., CC/MCC, ROM, POA):
Query opportunity/need for additional documentation:		
Clinical indicators/medical evidence:	Location in the health record:	Desired outcome/impact:

Physician Response: Yes___ No___		Date of response:	Physician agreed w/ request: Yes___ No___	
Revised DRG:	GLOS:	Relative weight:	SOI:	ROM:
Principal diagnosis:		Principal procedure:		
Disposition:	Review closed ___	Follow up review required ___	Date of next review:	
General comments:				

Clinical Documentation Improvement Clarification Form—Debridement

Date: _____ Patient Name: _____

CDI Professional: _____Health Record Number: _____

CDI Professional Phone #: _____Account Number: _____
(or place patient sticker)

Attention Medical Staff:

A review of the health record by the clinical documentation team found an opportunity for clarification regarding the debridement performed. Official coding guidelines define **excisional debridement** as the surgical removal or cutting away of devitalized tissue, necrosis, or slough. Official coding guidelines defines **nonexcisional debridement** as the nonoperative brushing, irrigating, scrubbing, or washing of devitalized tissue, necrosis, or slough.

The documentation in the record is unclear as to the type of debridement that was performed on this visit. The relevant information is provided below for your expedited review. **Please address these findings in the record by providing a specific procedure description and/or clarification of an existing procedure in the next progress note, dictated report, discharge summary and/or in an addendum.**

A response is requested within 24 hours.

Clinical Indicators/Medical Evidence	Location In The Health Record
1.	1.
2.	2.

Please clarify whether the debridement performed was excisional, nonexcisional, or undetermined AND the depth of the patient's debridement (skin, subcutaneous tissue, fascia, muscle, tendon, and/or bone)

Please note that a lack of response to this request does not reflect disagreement. If no additional documentation is warranted, please check the following box:

☐ I disagree with the need for additional documentation.

Reminder: ALL documentation MUST occur in the health record. This form is NOT part of the health record.

Thank you for your prompt response to this clarification request!

CDI Metrics for Success

There is more to a successful CDI program than hiring the appropriate staff and utilizing the available tools for documentation improvement. An additional and necessary component requires analyzing data to determine the success of the program. It is necessary to identify the appropriate criteria for screening data which will correctly measure the success or failure of a CDI program.

Report elements to consider when measuring program success may include:

- Severity of illness and risk of mortality
- Conditions most often requiring additional or more specific documentation
- Volume of queries issued
- Query success
- Clinicians most often queried
- Patient care area most often queried
- Employee activity
- Trended query, condition, clinician, employee, and case mix index data
- Case mix index change as a result of the CDI program
- Documentation habit changes as a result of the CDI program

The examples listed below identify several specific options to measure the performance of a CDI program. The CHF Monthly Physician Response to Query Process report on the following page provides an example of how important physician engagement is in the query process, which directly impacts a CDI program.

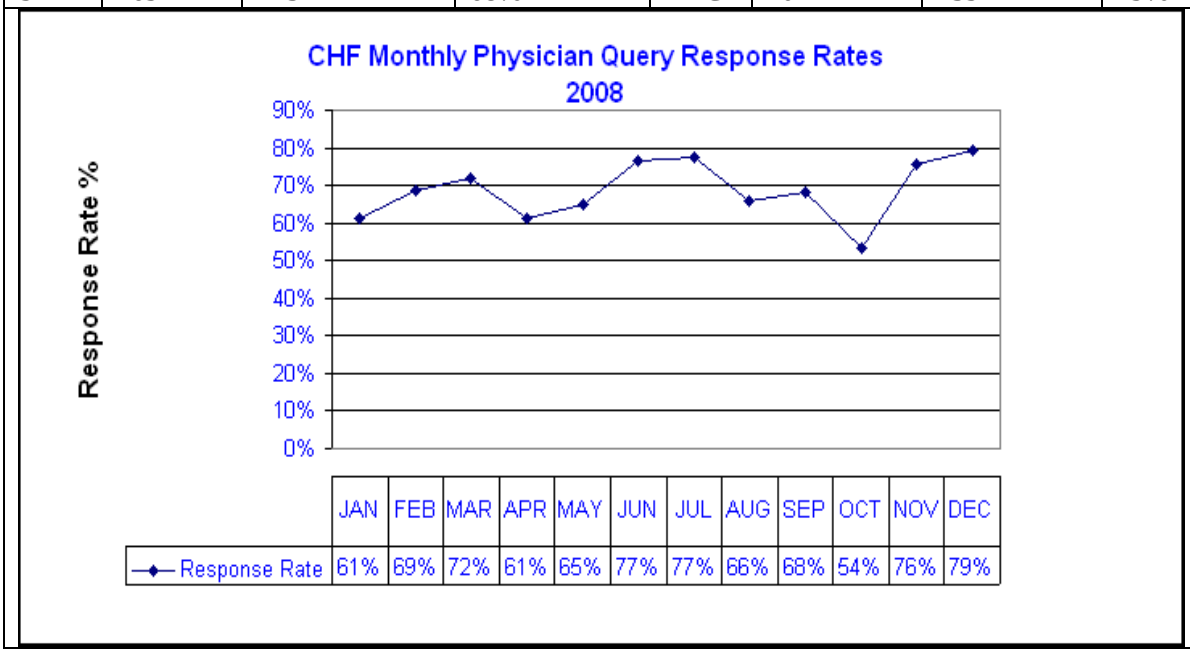
An additional report element, related to CHF, can include identification specific versus nonspecific documentation of heart failure (e.g., acute vs. chronic and systolic vs. diastolic). Any diagnosis or procedure can be used with this type of report, and this will depend on the specific needs of the healthcare facility.

Most healthcare facilities review case mix index (CMI) over time, both overall and by specialty. The example below documents quarterly CMI over a period of time, although this report can be designed based on the needs of the facility. For clinical documentation analysis purposes, an unexpected change in CMI could signal a possible problem with clinical documentation. It is important to have a clear understanding of the implications of changes in CMI and how a CDI program may impact it.

The final example focuses on secondary diagnoses, which is also tracked quarterly. The number of secondary diagnoses for inpatient cases can provide some insight into the level of detail of documentation available to the coding staff for code assignment. If this measure is used for CDI, the review team will want to make sure its members are familiar with the coding guidelines at the hospital and understand any possible limitations.

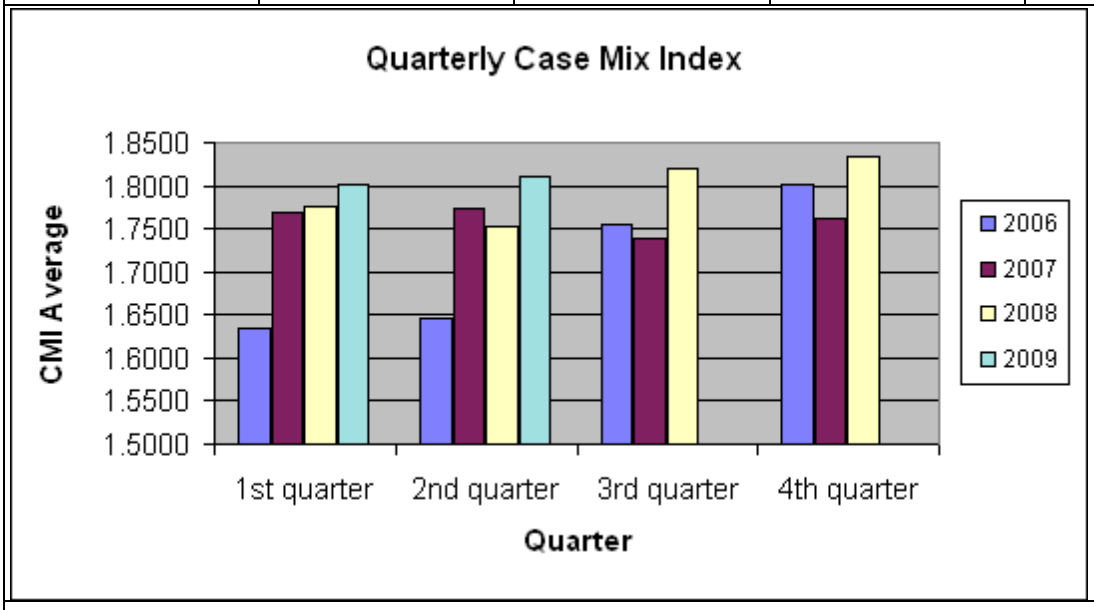
It may be helpful to establish metrics that have a threshold, which then reports to a dashboard using red, yellow, and green scoring to indicate status in each area.

CHF Monthly Physician Response to Query Process Report							
1st quarter				**2nd quarter**			
Mo.	# CHF Queries	# Answers	% Response	Mo.	# CHF Queries	# Answers	% Response
JAN	150	92	61%	APR	180	110	61%
FEB	89	61	69%	MAY	160	104	65%
MAR	110	79	72%	JUN	98	75	77%
3rd quarter				**4th quarter**			
Mo.	# CHF Queries	# Answers	% Response	Mo.	# CHF Queries	# Answers	% Response
JUL	172	133	77%	OCT	99	53	54%
AUG	132	87	66%	NOV	186	141	76%
SEP	169	115	68%	DEC	201	159	79%



Quarterly Case Mix Index Report

Year	1st quarter	2nd quarter	3rd quarter	4th quarter
2006	1.6342	1.6471	1.7539	1.8004
2007	1.7681	1.7734	1.7384	1.7621
2008	1.7762	1.7526	1.8189	1.8345
2009	1.8011	1.8101		

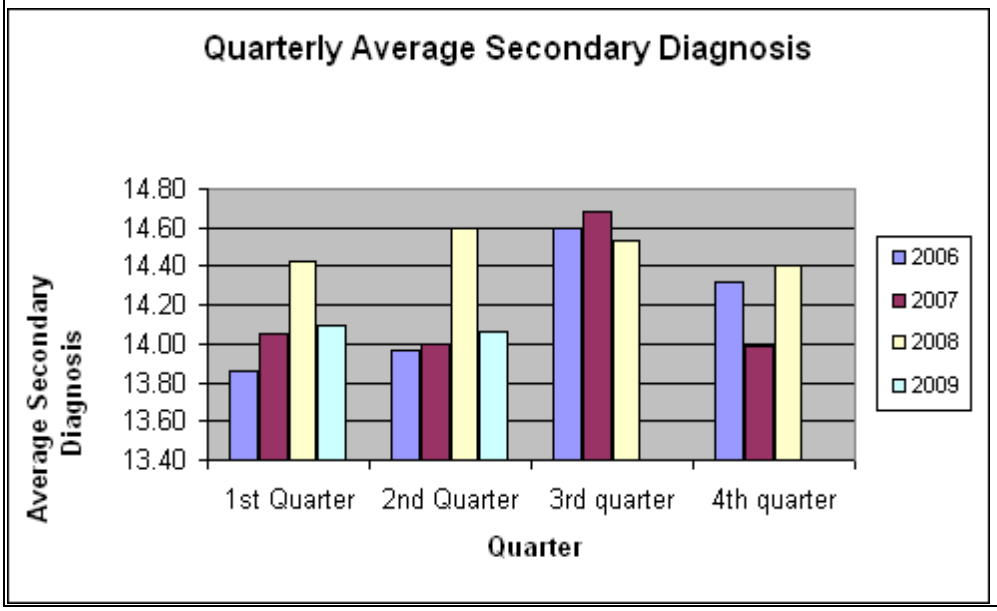


Number of Patients for the Quarter

Year	1st quarter	2nd quarter	3rd quarter	4th quarter
2006	8245	8007	8116	8351
2007	8349	7998	8205	8391
2008	8298	8016	8377	8432
2009	8460	8127		

Secondary Diagnosis Quarterly Report

	1st Quarter			2nd Quarter		
Year	# Patients	# Sec Dx	Avg # Sec per Pt	# Patients	# Sec Dx	Avg # Sec per Pt
2006	1521	21085	13.86	1601	22368	13.97
2007	1796	25231	14.05	1802	25231	14.00
2008	2123	30625	14.43	1963	28652	14.60
2009	2475	34887	14.10	2179	30642	14.06
	3rd Quarter			**4th Quarter**		
Year	# Patients	# Sec Dx	Avg # Sec per Pt	# Patients	# Sec Dx	Avg # Sec per Pt
2006	1681	24536	14.60	1605	22981	14.32
2007	1801	26445	14.68	1736	24291	13.99
2008	1916	27843	14.53	1873	26985	14.41
2009						



CDI Physician Role and Position Description

Accurate health record analysis combined with a complete understanding of ICD-9-CM coding rules and guidelines are necessary to ensure accurate inpatient ICD-9-CM code reporting and subsequent DRG assignment. A physician who understands the complexities of ICD-9-CM coding and the prospective payment system can often make medical determinations and communicate with physicians in partnership with the CDI team and health information personnel. Since there are few physicians proficient in inpatient ICD-9-CM coding, the prospective payment system, and DRG assignment, the following guidelines are presented for the prospective CDI physician advisor.

For purposes of this toolkit, the term "advisor" encompasses other terms such as: champion, liaison, and other similar terminology.

Benefits of the Physician Advisor Role

A trained CDI physician advisor on the medical staff can benefit the hospital by:

- Providing in-services regarding medical conditions for the CDI team and the health information department
- Serving as a liaison between the health information department and the clinical documentation specialist and the medical staff to encourage physician cooperation for thorough and specific documentation
- Providing education to the medical staff regarding DRGs, the Medicare Prospective Payment System, or other payment methodologies
- Assisting the hospital in reviewing and appealing potential coding and DRG denials

Selecting a Physician Advisor

Ideally, a hospital's physician advisor should be someone who communicates well and has the clinical respect of his or her peers. The needs and situations for each hospital will vary. In healthcare systems where there are multiple hospitals, a single physician might serve as the CDI physician advisor to more than one facility. Sometimes, a physician who already works in a contractual capacity (e.g., U/R physician advisor) might also assume the responsibility of CDI physician advisor. Or a facility may consider appointing more than one physician to this process.

The hospital should develop a contractual agreement with the physician to define responsibilities and compensation.

It is *ideal* if the physician is:

- Able to devote a minimum of 6–10 hours per week to review charts, consult with coders, and meet with the CDI professional and physicians regarding specific charts
- Willing to serve on the Utilization Review Committee (i.e., Performance Improvement Committee) and become involved in potential adverse DRG determinations
- Willing to conduct in-house education and training programs for medical departments related to PPS, DRGs, and review processes.
- Optimally, the physician advisor possesses leadership skills and is respected in the medical community.

Role of the Physician Advisor

In general, the CDI physician advisor will act as a liaison between the CDI professional, HIM, and the hospital's medical staff to facilitate accurate and complete documentation for coding and abstracting of clinical data, capture of severity, acuity and risk of mortality, in addition to DRG assignment. This will be accomplished by the following mechanisms:

Educating individual hospital staff physicians to link ICD-9-CM coding guidelines (e.g., coequal conditions, outpatient vs. inpatient) and clinical terminology to improve their understanding of severity, acuity, risk of mortality, and DRG assignments on their individual patient records.

Educating specific medical staff departments (e.g., Internal Medicine, Surgery, Family Practice) at departmental meetings regarding:

- Reasons why individual physicians should be concerned about correct disease reporting and the subsequent ICD-9-CM code capture of severity, acuity, risk of mortality, and DRG assignment, such as:
  - Physician performance profiling
  - Physician E&M payment and pay for performance
  - Appropriate hospital reimbursement and profiling for patient care
- Ways to provide improved health record documentation that specifically affect ICD-9-CM code assignment capture of severity, acuity, risk of mortality, and DRG assignment

As a subject matter expert, assist in the development of CDI articles for a hospital newsletter (if available) or other communication vehicles to further educate the medical staff.

Working with the HIM and CDI personnel on a routine basis to:

- Review selected health records concurrently or retrospectively
- Explain clinical issues that arise in chart review such as:
  - Types of congestive heart failure, anemia, etc.
  - Clinical explanation of sepsis, respiratory failure, aspiration pneumonia, etc.
- Help develop clinically appropriate and compliant physician queries to further clarify documentation

Facilitating complete health record documentation:

- Addressing admission denials
- DRG modifications
- Repetitive queries
- Interface directly with the third-party payers
- Aid in quality assurance, Medicare core measures, performance improvement, and other initiatives

How to Start and Maintain a CDI Program

Assessing the Need for a Program

Organizations can use several triggers to determine the potential benefits of a CDI program. This is primarily done through data collection and analysis.

A random retrospective chart audit can be performed to determine the potential query opportunity that exists in previously billed records. Organizations can isolate specific areas for the audit by defining certain record criteria (e.g., records with symptom principal diagnoses, without CC/MCC, and non-excisional debridement cases). A specific time frame can also be used from which to sample the records (e.g., discharges from April through June).

The impact of these findings can be reported in potential estimated dollar amounts, increase in relative weight/case mix index, and of captured additional length of stay days.

Certain output performance measures can also be used to identify areas of opportunity. Comparing the organization's case mix index, CC capture rates, and MCC capture rates (broken down by payer or grouper) to comparable facilities can emphasize the need for a CDI program. These data can be further scrutinized by DRG to give a better understanding of the clinical significance of the findings.

Hardware and Software Requirements

Each CDI professional should be equipped with a computer (laptop preferred) that has wireless Internet access and connects to a network printer. The laptop should be loaded with an encoder, query forms, and references. The references may vary depending on the needs of the facility and the CDI professional's service area.

Most encoder software vendors have reference packages available as add-on products. These include subscriptions to AHA *Coding Clinic*, AMA *CPT Assistant, Faye Brown ICD-9-CM Coding Handbook,* a medical dictionary such as Dorland's or Stedman's, *The Merck Manual, Elsevier's Anatomy Plates, Mosby's Manual of Diagnostic and Lab Tests, Dictionary of Medical Acronyms and Abbreviations,* and *Clinical Pharmacology Drug Reference.* Other recommended reference materials include Ingenix's *DRG Expert* and *Coders' Desk Reference for ICD-9-CM Procedures.*

Additional resources are also available through memberships to community resources such as AHIMA's Communities of Practices, HcPro's JustCoding.com, and the Association for Clinical Documentation Improvement Specialists. Refer to appendix A for additional reference Web sites and links.

A CDI professional reviewing outpatient encounters will require access to Local Coverage Determinations and will benefit from forums and Internet sites such as Coding 411 and Decision Health.

As facilities transition to true electronic health record, software vendors will need to provide programs that will accommodate this process. Potential software functions should include the ability to add a concurrent clarification query into an active chart, generation of reports to track and monitor CDI activities, and software capable of individualizing reports based on facility preferences and requirements. More advanced systems may utilize computer assisted coding software to identify possible opportunities for greater specificity in documentation.

Since coding is ever changing, both the CDI professional and hospital coding staff should have current coding resource materials, along with clinical references to enable the most efficient and accurate performance of the CDI and coding process.

Challenges

The greatest challenge of a CDI program is physician buy-in. Education of physicians is a prerequisite. Training and education should be tailored to specific services such as cardiology and gastroenterology, as each specialty has specific documentation requirements.

Trainers should emphasize how documentation will benefit physician performance profiles and reimbursement for their complete services. Additionally, appropriate hospital reimbursement provides increased resources for their hospital services. Physician education is never ending—especially in a teaching environment where attending physicians change services often and residents rotate through services.

A second challenge is hiring the right individual in the CDI position. There is no magic credential or license for this individual. The ideal candidate may come from various backgrounds, in particular HIM, nursing, and physician.

The CDI professional should have an excellent clinical background, strong oral and written communication skills, and basic knowledge of coding guidelines and conventions. These skills will empower them to provide a clinically succinct physician query and also be recognized as a member of the healthcare team. The CDI professional should understand the ethics and compliance issues surrounding the physician query process.

A third challenge is bridging the potential gap between the CDI professional and hospital coding staff. The CDI professional is a new player to the team, being brought in to communicate with physicians on documentation improvement issues. In the past this has been a function performed by the coding staff, most often retrospectively and less effectively (thus the need for a CDI program). Both the CDI professional and the hospital coders should be encouraged to recognize each other's skill sets and work as partners to accomplish the goal of solid documentation in support of the most specific code selection. Pairing coders with a CDI professional is helpful in enhancing their operational synergies and their interaction is a continually redefined collaboration.

Department Alignment

Starting a CDI department begins with planning the reporting structure.

Although CDI professionals review the concurrent health record and work closely with the coding department, they do not always fall under the same leadership alignment. The CDI team might report to the chief financial officer (CFO) or within departments, including health information management, quality, compliance, and case management.

The internal reporting structure is also important when planning how the team will disperse data and remain value-driven. Many CDI departments have a dedicated CDI manager who provides monthly reports while keeping a handle on the daily census, query compliance, and team support.

Getting Started

Starting the CDI program begins by analyzing 12 months of DRG data. Review data by DRG pairs, physicians, and specialties to identify documentation improvement opportunity. Identify the MS-DRGs that were coded without a CC and MCC. A team consisting minimally of HIM, case management, nursing, quality, and the physician advisor should review the chart documentation of the top 10 DRGs (review a sample of 100 charts; 10 by each DRG).

When reviewing documentation, the team should look at the following: treatment protocols, retrospective queries, and forms (e.g., anesthesia form for history documentation). They should identify the DRG billed, determine what the potential DRG could have been with additional documentation, and apply a dollar amount to the records reviewed. This review can serve as the basis of a documentation handbook for physicians.

Sample Process Flow

Launching a CDI program also requires drafting a process flow. The following sample applies to a paper-based facility; an EHR system would change this workflow.

> After midnight obtain a hospital census. Information should include (but not be limited to) room number, patient name, insurance carrier, date of admission, physician name, and admitting diagnosis.
>
> Each CDI professional will review every patient on assigned floor census every one to two days (or according to policy). New CDI programs may wish to begin performing chart reviews with high potential admit diagnosis and surgeries to review for complications.
>
> The CDI professional will initiate a worksheet on new admissions, which should be placed in a designated section of the health record on the floor. Each worksheet will include (but not be limited to) patient name, encounter number, admission date, working DRG, procedures, principal diagnosis, and additional diagnoses that impact the DRG or severity. (Note: the CDI worksheet might be electronic.)
>
> If a physician query opportunity is identified, the CDI professional should query the physician verbally, place a written query in the designated section of the health record with patient identifiers and CDI contact information, or submit the query electronically. Notation will be written on the worksheet regarding date, type of query (verbal, electronic, or written) and reason for query. If no query opportunity is identified, the CDI will continue to review the patient daily for further query opportunities.

Physician queries will be followed concurrently. If physician documentation affects an assigned DRG or severity, the CDI professional will update the working DRG on the worksheet. If the physician does not respond to the query, the CDI professional will contact the designated physician to review the current documentation and plan of care.

If the physician query is unanswered, a policy should be in place on how to manage this. The policy for managing unanswered queries should have minimal impact on the final coding and billing process. An unanswered query can be addressed in several ways. It can be:

- Designated as an incomplete chart and subject to the same rules for delinquency and suspension
- Forwarded to the physician advisor for direct follow up with the physician
- Forwarded through the medical peer review QA process

After discharge, the coder will assign a DRG based on the health record documentation, answered queries, and coding guidelines. The coder will document the final DRG on the CDI worksheet, attaching any queries left in the health record. DRGs without discrepancies will be billed, and the worksheet will be returned to the CDI department. The worksheet may be retained in the health record.

Charts with discrepancies (prior to final bill) will be given to the CDI professional assigned to the admission for a third review. If the CDI professional confirms or discovers documentation that would change the assigned DRG, a validation sheet is filled out supporting coding clinic with clinical evidence and quoted physician documentation for final coding review. If an opportunity remains, based on physician documentation (either unanswered query or ambiguous language), the CDI professional will contact the physician for final clarification.

All queries and validation sheets will be tracked and trended. Retention of queries should be addressed in facility policies and procedures. Auditors may request copies of queries in order to validate query language even if they are not kept as part of the legal health record.

Getting Physician Queries Answered

Rounding with physicians or communicating verbally is the best ways to get queries answered. Direct contact allows the opportunity for documentation education. CDI professionals should form appropriate queries and avoid asking for diagnoses not specifically supported in the health record.

Having a standard query form in a consistent area of the health record makes the query easy for the physician to find. Consider making the query a permanent part of the record. Attend patient care conferences and ask the other services to assist in getting the query answered. If the physician has a great relationship with a certain nurse, ask the nurse for assistance. Be a resource to the physician in other areas; for example, helping with their physician practice coding. Make the queries available online.

Maintaining a CDI Program

Maintaining a successful CDI program involves more than daily reviews and DRG assignments, it requires professional growth and a dynamic strategic plan.

Growth and collaboration with the medical staff can be reinforced by scheduling in-services and utilizing physician publications regarding disease process, new treatment plans, or surgical procedures. Include the coding staff to bring depth and understanding to grouper phraseology and CDI queries. Plan round tables with coding to discuss guidelines, updates, and ambiguous language in the health record. These meetings will stimulate conversations and help align the departments to reach billing accuracy and regulatory excellence. Encourage the staff to attend seminars, discuss journal articles, and network with other CDI programs in the area, all of which support best practice and professional development.

Quarterly meetings with administration and physician leadership, including physician advisors, helps maintain support for the CDI program. In addition to reporting metrics such as CMI, CC/MCC capture rates, query response rates, and SOI and ROM measures (see "CDI Metrics for Success," page 20), attendees can discuss recently encountered problems. Discussing possible solutions positions leadership to intervene in physician-related issues. Benchmark data from peer organizations can help demonstrate program success or areas where improvements are needed.

Developing articles and documentation tips sheets will bring value and help keep the program visible and vibrant. Working with the medical staff department (or office) could provide a vehicle to publish information and share it with the medical staff as a whole.

To be successful, a CDI program should be based on a strategic plan. Strategic planning is vital to the program and should always be aligned with the facility's mission. Effective plans are built on a foundation of purpose, vision, mission, and short- and long-term goals. This is a dynamic process that must be continually assessed and reevaluated. And although it is important to assist other departments, it is critical to avoid being over tasked.

Appendix A: Online Resources

An effective CDI program requires knowledge of current issues and an understanding of how quickly guidelines change. Below is a sampling of Web sites and links that will be beneficial to CDI professionals as they work to keep up with current issues in healthcare. This list is not all-inclusive, and there may be additional resources that would be beneficial to a CDI program.

AHIMA

American Health Information Management Association
http://www.ahima.org
AHIMA members have access to the association's "Communities of Practice," which offer resources and networking opportunities. Optional e-mail alerts update members on news within their communities. Communities of particular relevance to CDI include:

- Case Management
- Coding
- Coding Education
- Coding: Hospital Inpatient
- Concurrent Coding
- Data Management
- Documentation Improvement
- Physician Chart Auditors/Coding Auditors
- Recovery Audit Contractor

AHIMA members also have access to the AHIMA Body of Knowledge, which includes articles on CDI. At the time this toolkit was published, the Body of Knowledge offered the following CDI-related articles:

Leading Clinical Documentation Improvement: Three Successful HIM-Led Programs
Dimick, Chris
AHIMA Journal article
July 2008

Clinical Documentation Improvement—Gauging the Need. Starting Off Right
Rollins, Genna
AHIMA Journal article
September 2009

CDI Opportunities for HIM Professionals
Endicott, Melanie; Gardner, Amy
AHIMA Journal - Coding Notes
October 2009

Comprehensive CDI: Making It Happen

Pinson, Richard D.; Tang, Cynthia L.
AHIMA Convention
October 2008

Managing an Effective Query Process
AHIMA
AHIMA Practice Brief, AHIMA Journal
October 2008

An Ounce of Prevention: Using Clinical Documentation Improvement to Minimize Regulatory Risk
Primeau, Debra*
AHIMA Convention
October 2009
**(The AHIMA Convention presentation was done by Margi Brown, RHIA, CCS, CCS-P and Sue Muse, RHIA)*

In addition, AHIMA offers books and online education at
https://www.ahimastore.org/

ACDIS

Association of Clinical Documentation Improvement Specialists
http://www.hcpro.com/ACDIS/
This membership association includes resources, blogs, and networking for CDI professionals as well as information on the new credential of CCDS for clinical documentation specialists.

AHA Coding Clinic

http://www.ahacentraloffice.org/
The American Hospital Association issues *Coding Clinic for ICD-9-CM* quarterly, and while it may be included in the hospital's encoder/grouper software, CDI professionals should also have access to a hard-copy subscription to easily make note of guidelines changes.

Centers for Disease Control and Prevention (CDC)

The CDC provides a large variety of information related to diseases and injuries: http://www.cdc.gov/.

Centers for Medicare and Medicaid Services

IPPS regulations and notices are published online at the Acute IPPS center: http://www.cms.hhs.gov/AcuteInpatientPPS/. Annual proposed rules are usually posted early April and final rules by the first week of August.

Recovery Audit Contractors information is available at: http://www.cms.hhs.gov/RAC/.

Medicare Conditions of Participation outline rules and regulations for Medicare hospitals, including documentation requirements, are published at http://www.cms.hhs.gov/CFCsAndCoPs/06_Hospitals.asp

Medicare requirements for Hospital-Acquired Conditions and POA are available at http://www.cms.hhs.gov/HospitalAcqCond/

CMS manuals—such as the benefit policy manual, claims processing manual, and national coverage determinations manual—are available at http://www.cms.hhs.gov/Manuals/IOM/list.asp.

The ICD-9-CM Coordination and Maintenance Committee proposals and minutes for procedures are maintained on the CMS Web site rather than NCHS. See: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp

CMS offers free Web-based training at http://www.cms.hhs.gov/MLNEdWebGuide/. Topics include diagnosis coding using ICD-9-CM, Medicare fraud and abuse, the world of Medicare, and the Acute Hospital Inpatient Prospective Payment System.

Register for e-mail updates of selected CMS topics at http://www.cms.hhs.gov/. (Scroll down to the "Featured Content" section.)

The Joint Commission

Information related to the Joint Commission Performance Measures may be found at http://www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement/.

Medical Administrative Contractor (MAC)/Fiscal Intermediary (FI)

A listing of state Medicare Administrative Contractors (or Fiscal Intermediaries) is available at http://www.cms.hhs.gov/MedicareContractingReform/. (Look for A/B MAC jurisdictions.)

National Center for Health Statistics (NCHS)

The NCHS site http://www.cdc.gov/nchs/ includes ICD-9-CM Coordination and Maintenance Committee proposals and minutes for diagnoses, updates to *Official Guidelines for Coding and Reporting*, and ICD-10 links.

National Healthcare Quality Report

The NHQR is a comprehensive national overview of the quality of healthcare in the United States. The full report can be viewed at http://www.ahrq.gov/qual/nhqr05/nhqr05.pdf.

Office of Inspector General (OIG)

OIG publishes a work plan that outlines target areas in healthcare at http://oig.hhs.gov/08/Work_Plan_FY_2008.pdf

PEPPER

The Program for Evaluation Payment Patterns Electronic Report is available at http://www.pepperresources.org/

Report Cards

The following organizations offer publicly available hospital ratings:
www.healthgrades.com
www.checkbook.org
www.jcaho.com
http://www.leapfroggroup.org/

Medical References

An almost unlimited supply of medical disease articles and resources is available at:
http://www.guideline.gov/

Harrison's Principals of Internal Medicine is available at:
www.harrisons17.com

Medline Plus is an excellent reference site for clinical information:
http://medlineplus.gov/

CDI Article Links

Roop, Elizabeth S. "RHITs Take the Helm of Documentation Improvement." *For The Record* 19, no. 2 (Jan. 2007). www.fortherecordmag.com/archives/ftr_01222007p18.shtml

"Clinical documentation improvement in MS-DRGs as a strategy for compliance: facilities may consider clinical documentation audits to look for coding errors." *Journal of Health Care Compliance*, January 2008. http://goliath.ecnext.com/coms2/gi_0198-456175/Clinical-documentation-improvement-in-MS.html

Gold, Robert S. "What Clinical Documentation Improvement Is – and What It's Not." For the Record 19, no. 6 (Mar. 2007). http://www.fortherecordmag.com/archives/ftr_03192007p8.shtml

Hahey, JoAnne R., and Mel Tully. "Case Study: The Rewards of Accurate Clinical Documentation." Healthcare Financial Management Association, October 2008. https://www.hfma.org/Publications/E-Bulletins/Business-of-Caring/Archives/2008/October/Case-Study--The-Rewards-of-Accurate-Clinical-Documentation/

Appendix B: Policies and Procedures

Following are examples of six policies and procedures that may be used in established or new CDI programs. Please note that these are samples that can be used as is or adapted to reflect the specific needs of the healthcare organization.

Requesting Clinical Documentation Clarification

Purpose
To provide a standardized process of communicating with the medical staff and providers in order to achieve complete and accurate documentation. Appropriate clinical documentation clarification requests will improve the accuracy, integrity, and quality of patient information in the health record. Clinical documentation clarification requests are an established mechanism to clarify ambiguous, incomplete, unclear, or conflicting documentation in the health record.

Scope
These guidelines apply to all health records (inpatient and outpatient) and all personnel responsible for performing, supervising, or monitoring provider documentation.

Responsibility
It is the responsibility of the CDI professional to implement these guidelines. It is the responsibility of the individual to implement, enforce, update, and ensure compliance with these guidelines.

Definitions
CDI professional—an individual who reviews health records on a concurrent basis and aids the provider if opportunities to improve documentation are identified
Clarification—to make clear or easier to understand (e.g., a needed clinical interpretation of a given diagnosis or condition based on treatment, evaluation, monitoring, and/or services provided; a needed agreement of diagnoses by other non-physician members of the healthcare team; a needed diagnosis for conflicts between attending and consulting physicians)
Coding professional—an individual who translates the descriptions of diseases, injuries, and procedures into numeric or alphanumeric designations for reimbursement, morbidity, clinical care, research, and education
Concurrent—pre-discharge; patient is in-house
Provider—any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis
Post billing—post-discharge after billing
Retrospective—post-discharge before billing
Specification—a detailed description (e.g., documentation to more accurately reflect the acuity, severity, and the occurrence of events to represent an accurate and complete description of the patient's clinical condition)

Procedure Overview/Background

Health record documentation is used for a multitude of purposes, including:

- Serving as a means of communication between the provider and the other members of the healthcare team providing care to the patient
- Serving as a basis for evaluating the adequacy and appropriateness of patient care
- Improving the quality and effectiveness of patient care
- Improving clinical decision making
- Monitoring resource utilization
- Providing data to support insurance claims/ensure equitable healthcare reimbursement
- Permitting valid clinical research, epidemiological studies, outcomes, and statistical analyses
- Assisting in protecting the legal interests of the patients, healthcare professionals, and healthcare facilities

It is imperative that health record documentation be complete, legible, accurate, and timely. If documentation in the health record appears ambiguous, incomplete, unclear, or conflicting, the provider will be asked to clarify the documentation.

Clinical documentation clarification requests may be concurrent or retrospective (see definitions above).

Provider Responsibilities

The provider is responsible for complete, accurate, timely, and legible documentation in the health record. Health record entries should be documented at the time service is provided and authenticated by the author. The response to clinical documentation clarification requests must be documented, dated, and timed in the health record.

Providers shall review and respond to clinical documentation clarification requests concurrently or prior to discharge whenever possible.

Provider documentation entries in the health record should:

- Address the clinical significance of abnormal test results
- Support the intensity of patient evaluation and treatment and describe the thought processes and complexity of medical decision making
- Include all diagnostic and therapeutic procedures, treatments, and tests ordered and performed, in addition to the results
- Include any changes in the patient's condition, including psychological and physical symptoms
- Include all conditions that coexist at the time of admission, that subsequently develop, or that affect the treatment received and the patient's length of stay

Requirements for Developing Provider Communications

Prior to initiating a clinical documentation clarification request, there must be clinical evidence in the health record to support such communication. Providers will be contacted:

- When there is conflicting, ambiguous, incomplete, or unclear information in the health record

- When further specificity is needed to more accurately reflect the acuity, severity, and the occurrence of events (e.g., resent on admission)
- When further specificity is needed in documentation to represent an accurate and complete description of the patient's clinical condition
- To determine the significance of abnormal operative, procedural, pathologic, radiologic, or other diagnostic findings
- For agreement and documentation of diagnoses documented by other non-physician members of the healthcare team (e.g., nutrition, wound care team)
- For clarification of principal diagnosis and/or principal procedure
- For clarification of conditions/procedure names which do not use approved hospital abbreviations
- For clarification if there are conflicts of diagnoses between a physician consultant and the attending physician

CDI Professional Provider Documentation Clarification Request
The CDI professional will contact the patient's provider if opportunities to improve documentation are noted during the concurrent review (see definition above) of the patient's health record.

Clinical documentation clarification requests can be made verbally and in person when the provider is on the patient care unit.

Clinical documentation clarification requests will be written when a verbal communication opportunity does not present itself.

Clinical documentation clarification requests should be clear and concisely written or clearly dialogued. Clinical evidence from the health record will be presented (in written or oral communication) to support the need for documentation clarification (e.g., a needed clinical interpretation of a given diagnosis or condition based on treatment, evaluation, monitoring, and/or services provided).

Providers shall review and respond to CDI professional clinical documentation clarification requests concurrently/prior to or at discharge.

Providers shall respond to the clarification request by documenting any applicable condition/procedure the next time they document in the progress notes.

If the provider, after reviewing the clarification request, does not believe further clarification is necessary, he or she shall provide such a response back to the CDI professional verbally or in writing.

The CDI professional will check provider response to queries during the hospital stay. The CDI professional will update the CDI monitor after the provider has responded in the progress notes (e.g., documented the condition(s) or procedure(s) or indicated a disagreement on the query).

When a health record is received into the HIM department, the coding professionals will remove the query from the health record if a response was received.

The closure process may be directed by the CDI manager to determine whether query was responded to and/or agreed with after discharge and make adjustments as appropriate in the CDI monitor.

Unanswered Clinical Documentation Clarification Request
A query that is generated by the CDI professional concurrently and is not answered by the provider before the patient is discharged is handled as follows:

- All unanswered concurrent physician queries will be reviewed by the CDI manager and the health record will be returned to the coding professionals for follow-up with the provider when appropriate.
- It is the responsibility of the CDI professional to contact the provider and obtain a response to the query.
- If the query is agreed to, the provider will document appropriately in the progress notes. The health record is then returned to the coding professional.
- If the query is not agreed to, the provider or the CDI professional will document the disagreement on the query and return the health record to the coding professional.
- Unanswered clinical documentation clarification requests are not intended to be held beyond the facility's prescribed 'bill hold' time frame.

Provider Communication Education and Tracking
Providers should be educated on the importance of concurrent documentation in the health record to achieve complete and accurate documentation.

Providers should be educated that CDI staff will ask for clarification when documentation is ambiguous, unclear, incomplete, or conflicting.

CDI provider communications will be tracked and trended to determine educational opportunities for providers based on the type, volume, and response to provider communication.

Ongoing physician education will be maintained via electronic, story board, and face-to-face communication every 1–2 months.

CDIP Orientation Database

Purpose: To monitor and identify the attendance of physicians oriented to the Clinical Documentation Improvement Program for a more effective hospital-wide approach to educate physicians and healthcare providers.

ENP Orientation Process

(Electronic notification of new physicians and allied health professionals)

Purpose: To establish a process in which the CDI professional is notified of newly hired physicians and allied health professionals requiring orientation to the program and are scheduled to receive the required orientation to the clinical documentation improvement program.

Meetings with Department Chair Physicians

Purpose: Meet quarterly or bi-annually with individual physician department chairs to review and discuss CDIP data. The CDI professional will generate reports for each meeting. When identified, educational opportunities will be discussed to encourage documentation enhancement to reflect an accurate DRG/principal diagnosis assignment, severity of illness, physician/hospital scores, length of stay and use of hospital resources and physician evaluation and management.

Secondary Diagnosis

Purpose: Generate a quarterly report of secondary diagnoses to monitor the number of patients, total and average number of secondary diagnoses per patient, and monitor extremes, outliers, and fluctuations in the data. These reports will be reviewed and discussed with the HIM director and the appropriate department chair.

Case Mix Index Report by Physician Group

Purpose: This report will allow the CDI professional to review CMI for individual providers and their practices. Case mix index monitors potential fluctuations in provider severity of illness and may identify those providers requiring additional documentation/coding education.

Appendix C: Glossary of Terms

APR-DRG	All-patient refined diagnosis related group
CC	Complication/Comorbidity
CDI	Clinical documentation improvement
CDI professional	An individual who reviews health records on a concurrent basis and aids the provider if opportunities to improve documentation are identified
CDIP	Clinical documentation improvement program
CDIS	Clinical documentation improvement specialist
CDS	Clinical documentation specialist
CMI	Case mix index – the average DRG weight for all patients over specified time period
CMS	Centers for Medicare and Medicaid Services
Coding professional	An individual who translates the descriptions of diseases, injuries, and procedures into numeric or alphanumeric designations for reimbursement, morbidity, clinical care, research, and education
Concurrent	Prior to discharge; the patient is in-house
DRG	Diagnosis related group
E&M	Evaluation and Management CPT-4 codes
EF	Ejection fraction
EHR	Electronic health record
GLOS	Geometric length of stay
HAC	Hospital acquired condition
HIM	Health information management
ICD-9-CM	International Classification of Diseases, 9th edition, Clinical Modification
LOS	Length of stay
MAC	Medicare Audit Contractors
MCC	Major complication/comorbidity
MIC	Medicaid Integrity Contractors
MS-DRG	Medicare severity diagnosis related group
POA	Present on admission
Post bill	Post-discharge, after initial billing
QA	Quality assurance

Query	A question posed to a provider to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedures codes in the patient's health record
RAC	Recovery Audit Contractors
Relative weight	The average resources required to care for a patient assigned to a specific DRG in relation to the national average of resources used to treat all Medicare cases
Retrospective	Post-discharge, before billing
ROM	Risk of mortality
SME	Subject matter expert
SOI	Severity of illness
UR	Utilization review
ZPIC	Zone Program Integrity Contractors